LOUDOUN COUNTY, VIRGINIA **FAX: 571-258-3212**

HEALTH PLAN ENROLLMENT/CHANGE FORM (RETIREE)

Plan Year 2011
1/1/11 – 12/31/11

Enrollment Type

◯ New Enrollment ◯ Retirement
◯ Status Change* ◯ Cancel Coverage
◯ Open Enrollment ◯ Coverage Change

**Must complete the Change in Family Status Election Form*

Retiree Name _____
Last *First* *MI*

Address _____
Street *City* *State* *Zip Code*

Email: _____

Coverage Level

◯ Individual Only
◯ Individual + 1
◯ Family

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Date of Hire _____ SSN_____ Sex _____ Marital Status **S M D W**

Medical Plan Options

◯ CIGNA POS
◯ CIGNA OAP
◯ Medicare Advantage (Post 65 Retirees only)

Employee PCP ID# _____ Existing Patient Y / N

Spouse _____ SSN _____ Date of Birth _____ Sex _____
◯ *Add* ◯ *Remove* ◯ *No Change* *required* *required*

Primary Care Physician ID# _____ Existing Patient Y / N
(CIGNA POS Only) *(CIGNA POS Only)*

Dependent Child _____ SSN _____ Date of Birth _____ Sex _____
◯ *Add* ◯ *Remove* ◯ *No Change* *required* *required*

Primary Care Physician ID#_____ Existing Patient Y / N Full Time Student Y / N Disabled Y / N
(CIGNA POS Only) *(CIGNA POS Only)*

Dependent Child _____ SSN _____ Date of Birth _____ Sex _____
◯ *Add* ◯ *Remove* ◯ *No Change* *required* *required*

Primary Care Physician ID#_____ Existing Patient Y / N Full Time Student Y / N Disabled Y / N
(CIGNA POS Only) *(CIGNA POS Only)*

Dependent Child _____ SSN _____ Date of Birth _____ Sex _____
◯ *Add* ◯ *Remove* ◯ *No Change* *required* *required*

Primary Care Physician ID# _____ Existing Patient Y / N Full Time Student Y / N Disabled Y / N
(CIGNA POS Only) *(CIGNA POS Only)*

Other Health Coverage

Do you, your spouse, or any of your covered dependents have other health insurance coverage that will be continue in addition to this plan?

◯ Yes* ◯ No

If yes, please indicate below who will be covered/type of plan? High Deductible Health Plan = HDHP* HMO/PPO/POS = Non-HDHP Medicaid Medicare A, B, C, and/or D

**You may not be enrolled in another Medicare Advantage Plan and simultaneously participate in the Medicare Advantage Plan for retirees with Loudoun County.*

Spouse's Employment

Is your spouse an employee of: ◯ Loudoun County Government ◯ Loudoun County Public Schools

If yes, please provide your spouse's name. _____

Certification

As a participant in the Loudoun County Retiree Health Plan, I understand that I must make this election upon retirement. Coverage changes may only be made during an open enrollment period or within ***30 days of a qualifying event***. I understand that I am not covered under the County's Retiree Group Health Plan until I have elected benefits under the plan and the election has been accepted by Human Resources/Benefits. The *effective date* for a retiree or dependent(s) who initially elects coverage or who elects to change coverage under the Plan due to a qualifying event shall be *the first of the month following:*

- ✓ The date the retiree incurs a qualifying change in family, dependent, or employment status; or
- ✓ The date the retiree submits a completed and signed health plan enrollment/change form.

As a participant in the Loudoun County Retiree Health Plan, I certify that if I have applied for spousal or dependent health plan coverage, the dependents listed on my enrollment form are my legal spouse and/or child(ren) who is (are) under age 26. Eligibility verification documents required for all enrolled dependents. I must notify the Loudoun County Benefits Office within **30 days** of any change in status, which would cause any of my covered dependents to cease to be eligible for benefits under the County's Retiree Health Plan. These changes include, but are not limited to, death of a dependent, divorce, or reaching the policy age limit. If I fail to notify the Loudoun County Benefits Office by filing the appropriate termination and/or change forms, I will be responsible for any claims, and/or premiums paid on behalf of any individual who ceased to be eligible for benefits under the policy. It is my responsibility to keep informed of any changes to the plan that might affect my or my dependent(s) eligibility. I further understand that failure to notify the Loudoun County Benefits Office of a timely change in a dependent eligibility, my dependent may lose their COBRA rights. I understand that I may change my election (decreasing or dropping coverage) only during the annual open enrollment period or upon certain qualifying events specified under the IRS Section 125 Pre-Tax Rules and Regulations (refer to Qualifying Event Changes document for details). **This authorization will be effective for this plan year and subsequent years, unless modified by completion and acceptance of a new Health Plan Enrollment/Change Form.**

Medicare Enrollment Required:
Retirees (including disability retirees) / spouses who are eligible for Medicare Parts "A" & "B" must enroll for Medicare coverage and provide proof of enrollment within 45 days of their effective date in order to retain coverage under the County's plan.

Re-enrollment Rights:
Retirees may waive coverage under the retiree health plan if coverage is available under another plan, and later opt back in at the same level of coverage in effect at the time of their retirement with proof of creditable coverage (requires continued coverage with no lapse in coverage).

Premium Payments:
Flexible Benefits Administrators, Inc (FBA) is the administrator of retiree billing services. You will receive a welcome letter that will detail your payment options. All premium payments and billing correspondence should be directed to FBA.

Retiree Signature _____ Date _____

County of Loudoun, 1 Harrison St SE, 4th Fl. MS# 41A, Leesburg, VA 20177